The Florida Senate

Interim Project Report 2008-135 *November 2007*

Committee on Health Regulation

REVIEW REGULATORY REQUIREMENTS FOR HOME HEALTH AGENCIES

SUMMARY

The unusually rapid growth over the past several years, particularly in South Florida, in the number of licensed home health agencies and the indications of possible quality-of-care problems and Medicaid fraud have led to concerns about the adequacy of the state regulatory environment for home health agencies. The proliferation of home health agencies coincides with the elimination of certificate-of-need review for new home health agencies in July 2000 and the adoption of a prospective payment system for Medicare reimbursement of home health agencies in October 2000.

This report examines factors that affect entry of new home health agencies into the market and the extent to which the market is meeting the need for home health services throughout the state. The report looks at indicators of quality-of-care and Medicare/Medicaid fraud and abuse problems in the home health industry.

Senate professional staff recommends that: a cap be placed on new home health agencies licensed in the state by geographical area; the Agency for Health Care Administration (AHCA) be notified upon termination of an agency's director of nursing; the AHCA develop standards of care related to responsibilities of the director of nursing for oversight of services provided directly or indirectly by the home health agency; the director of nursing's span of control be limited based on patient count; the AHCA conduct more frequent surveys of home health agencies; and penalties related to deficiencies be enhanced. Further, staff recommends that AHCA evaluate and enhance, if appropriate, the precertification process that authorizes Medicaid to pay for certain longer-term services and enhance edits in the Medicaid system to avoid payment for duplicated services already paid for by Medicare for dually eligible patients.

BACKGROUND

Home Health Services/Home Health Agencies

Home health agencies are organizations that are licensed by the AHCA to provide home health services and staffing services. Home health services are health and medical services and medical supplies furnished by an organization to an individual in the individual's home or place of residence. The services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation);
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[1]

Staffing services are provided to health care facilities or other business entities on a temporary basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency.[2]

A home health agency may also provide homemaker and companion services without additional licensing or registration. These services do not involve hands-on personal care to a client and typically include housekeeping, meal planning and preparation, shopping assistance, routine household activities, and accompanying the client on outings.

Home health agency personnel are employed by or under contract with a home health agency.

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[1] Section 400.462(13), Florida Statutes.

[2] S. 400.462(25), F.S.

State Licensure Requirements

Since 1975, home health agencies operating in Florida have been required to obtain a state license.[3] The licensure requirements for home health agencies are found in the general health care licensing provisions of part II of ch. 408, F.S., the specific home health agency licensure provisions of part III of ch. 400, F.S., and the minimum standards for home health agencies in chapter 59A-8, Florida Administrative Code. As of August 23, 2007, there were 1,865 licensed home health agencies in Florida.[4]

A home health agency license is valid for 2 years, unless sooner suspended or revoked.[5] If a home health agency operates related offices, each related office outside the county where the main office is located must be separately licensed.[6] The biennial licensure fee is $1,660.

The issuance of an initial license to a home health agency is based on the submission of a signed and notarized, complete and accurate home health agency application and the results of a survey conducted by the AHCA. The application forms require:

- The applicant's name and business address;
- Information about the ownership, management, and controlling interests of the proposed licensee;
- Documentation about compliance with local zoning requirements;
- Proof of the applicant's legal right to occupy the property;
- Evidence of compliance with background screening requirements;
- An indication of the hours of operation;
- A listing of each county in which the applicant expects to provide services;
- Submission of financial schedules signed by a Certified Public Accountant indicating the financial ability of the home health agency to operate;
- A current bank statement showing sufficient funds in the home health agency's name;
- Proof of malpractice and liability insurance coverage;
- An indication of whether the home health agency intends to be a Medicare or Medicaid provider;
- A listing of services to be provided;
- Information about whether service personnel are direct employees or contracted staff; and
- Qualifications of the Administrator, Alternate Administrator, and Director of Nursing.

Once the AHCA receives an application, it has 30 days to send an omission letter to the applicant describing items needing correction or requesting additional information. The applicant has 21 days from the receipt of the letter to make corrections and provide missing information to the AHCA. Once the application is determined to be complete, the AHCA field office is notified to schedule an initial licensure survey. The AHCA must take final action on an initial application within 60 days after receipt of all required documentation.[7] The applicant is prohibited from beginning to serve patients until the survey is passed and the license has been issued.

For licensure renewal, the home health agency must submit a signed and notarized renewal application and fee of $1,660. The renewal application form requires information on: changes from the previous application; evidence of compliance with background screening requirements for individuals not previously submitted; a listing of services to be provided in the subsequent period and whether those services will be provided by employees or contracted staff; and the annual number of patients admitted by the home health agency.

The AHCA conducts unannounced licensure surveys every 36 months, unless a home health agency has requested an exemption from state licensure surveys based on accreditation by an approved accrediting organization. The Home Health Agency State Regulation Set that is used in conducting surveys contains over 100 standards and surveyor guidelines, which are based on Rule 59A-8, Florida Administrative Code. The AHCA also conducts inspections related to complaints.

Medicare Certification Requirements

To receive reimbursement from Medicare, a home health agency must apply to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for certification as a Medicare provider. Certification is based on the home health agency meeting the conditions of participation set forth in 42 Code of Federal Regulations, Ch. IV, Part 484 (Subparts A, B, and C), and demonstrating compliance with minimum standards during an on-site

[3] Ss. 36 – 51 of ch. 75-233, Laws Of Florida (L.O.F.)
[4] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation, as of 8/23/2007.
[5] S. 408.808(1), F.S.
[6] S. 400.464(2), F.S.
[7] S. 408.806(3)(c), F.S. See also s. 120.60(1), F.S.

survey inspection. A home health agency must be operational and have a minimum of 10 patients receiving skilled care before the survey is conducted. The federal government contracts with the AHCA to perform the certification survey inspections. The initial certification survey generally occurs 9-12 months after the home health agency submits the application to Medicare. In Florida, the ongoing Medicare certification surveys are usually performed concurrently with a state licensure survey.

As of August 23, 2007, of the 1,865 licensed home health agencies in Florida, 873 were certified for Medicare (47 percent of the licensed home health agencies).

Medicare Prospective Payment System

Effective October 1, 2000, Medicare implemented a prospective payment system for home health agencies.[8] Under prospective payment, Medicare pays home health agencies a predetermined base payment. The payment is adjusted for the health condition and care needs of the patient (case-mix adjustment) and for the geographic differences in wages for home health agencies across the country. There are additional adjustments, including a special outlier provision to ensure appropriate payment for those patients who have the most expensive care needs.[9]

The prospective payment system provides home health agencies with payments for each 60-day episode of care for each patient. There are no limits to the number of episodes a patient who remains eligible for the home health benefit can receive.

The United States General Accounting Office (GAO) studied the Medicare prospective payment system for home health agencies to assess, among other things, the system's impact on the industry. The GAO found that in 2001, the aggregate Medicare margin for home health services provided by freestanding home health agencies was 16.2 percent; and in 2002, the aggregate margin rose to 17.8 percent.[10] The Medicare Payment Advisory Commission (MedPAC) reported to Congress that the aggregate margin in 2004 and 2005 for freestanding home health agencies was 16.0 percent and 16.7 percent, respectively.[11]

Medicaid Provider Enrollment and Reimbursement

To enroll as a Medicaid provider, a home health agency must be licensed under part III of ch. 400, F.S., and meet the Medicare conditions of participation.[12] In addition, the home health agency must meet the general Medicaid provider enrollment requirements contained in the *Florida Medicaid Provider General Handbook*[13] and the specific home health agency qualifications in the *Home Health Services Coverage and Limitations Handbook.* All parent offices, branch offices and subunits are required to enroll in Medicaid and receive their own unique Medicaid provider numbers. Unless exempt, a surety bond is required for home health agencies if there have been (within the past 5 years) or currently are sanctions or terminations (voluntary or involuntary) involved. It takes approximately 6-9 months from submission of the application for a home health agency to become enrolled as a Medicaid provider.

Generally Medicaid reimburses home health agencies a fixed amount per visit. Private duty nursing services and personal care rendered by a home health aide to certain medically complex recipients are reimbursed on an hourly basis. Each covered service must be medically necessary for the treatment of a specific documented medical disorder, disease, or impairment, and not duplicate another provider's service.

As of August 23, 2007, there were 524 licensed home health agencies enrolled as providers in the Florida Medicaid program (28 percent of the licensed home health agencies).

Former State Certificate-of-Need Requirements

The Certificate-of-Need (CON) program is a market-entry regulatory review process that requires certain health care related projects to be approved by a state

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[8] *Overview of Home Health PPS*, Centers for Medicare and Medicaid Services, found at <http://www.cms.hhs.gov/HomeHealthPPS/> (Last visited on October 4, 2007).

[9] 42 CFR ch. IV, Part 484, Subpart E.

[10] GAO-04-359.

[11] MedPAC Report to Congress: Medicare Payment Policy, March 2007, page 194.

[12] *Florida Medicaid, Home Health Services Coverage and Limitations Handbook*, Agency for Health Care Administration, found at <http://floridamedicaid.acs-inc.com/XJContent/Home_Health_ServicesHB.pdf?id=000000000281> (Last visited on October 4, 2007).

[13] *Florida Medicaid, Provider General Handbook*, Agency for Health Care Administration, found at <http://floridamedicaid.acs-inc.com/XJContent/GH_07_070101_Provider_General_ver1.1.pdf?id=000004590898> (Last visited on October 24, 2007).

agency or other statutorily-designated body prior to implementation of those projects. Florida's CON law took effect on July 1, 1973.[14]

Home health agencies were made subject to CON regulation in 1977 by s. 2 of ch. 77-400, L.O.F. In 1983, the CON requirement was repealed for home health agencies that were not certified or seeking certification as a Medicare home health service provider.[15] The Legislature repealed the requirement that Medicare-certified home health agencies receive CON approval, effective July 1, 2000.[16] The repeal was conditioned upon Medicare adopting a prospective payment system for home health agencies. The agencies that administered the CON requirement for home health agencies over the 13 years that the CON requirement was in effect had great difficulty in establishing a need methodology that could sustain administrative challenges. Three rules establishing home health agency need methodologies were ruled invalid.

The CON program is most effective for projects that require significant capital expenditures. Capital expenditures by home health agencies, in general, are insignificant.

METHODOLOGY

Senate professional staff reviewed state and federal licensure/certification requirements and regulatory standards for home health agencies in Florida, analyzed a recent report prepared by the AHCA,[17] attended the Florida House of Representatives Committee on Health Innovation's Workshop on Medicaid Fraud, and met or conversed with AHCA personnel and representatives from the regulated industry.

FINDINGS

Market Entry/Access

Certificate of Need

While CON has been criticized as a barrier to free market activity in the health care sector, the lack of a barrier since 2000 may be making it too easy for poorly qualified home health care providers to enter the market. As of August 6, 1999, prior to repeal of the CON requirement for Medicare certified home health agencies, there were 1,186 licensed home health agencies in the state. As of August 23, 2007, there were 1,865 licensed home health agencies in the state,[18] an increase of 677 (57 percent) new agencies. The growth has been uneven around the state. Seventeen counties experienced a reduction in the number of licensed home health agencies during this period. Almost all of these counties are rural. However, despite the reduction in the number of licensed home health agencies in the rural counties, there is no indication that requested home health services are unavailable in these areas as a home health agency licensed in one county may serve clients in multiple counties.

In Miami-Dade County, however, the number of licensed home health agencies went from 216 in August 1999 to 651 in August 2007 (435 newly licensed home health agencies – a 200 percent increase). The increase in Miami-Dade County represents 64 percent of the statewide increase in licensed home health agencies. The growth in Broward County, from 153 to 214 licensed home health agencies, represents an increase of 61 agencies or 9 percent of the statewide increase.

While CON regulation might have prevented the proliferation of licensed home health agencies over the past several years, particularly in Miami-Dade County, reinstating a CON requirement for new home health agencies may not be the solution. Imposing a CON requirement would limit the number of new home health agencies in the future, but would not address the number of already licensed home health agencies and the uneven distribution of home health agencies around the state. Requiring a CON for new home health agencies could have a deterrent effect on new home health agencies that want to specialize in a limited number of home health services. In addition, because home health agencies are able to expand to meet market demand by increasing staff, holders of a CON and already licensed home health agencies would have the ability to limit the participation of new agencies in the market.

Moratorium or a Cap on Issuance of New Licenses

Limiting the entry of new home health agencies into the market could be accomplished by imposing a moratorium on the issuance of new licenses or by establishing a cap on the number of new licenses that the AHCA could issue during a specified period of

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[14] See ch. 72-391, L.O.F.

[15] See s. 1 of ch. 83-244, L.O.F.

[16] See ch. 2000-256, L.O.F., and ch. 200-318, L.O.F.

[17] *Licensure Application Practices and the Rapid Increase in the Number of Home Health Agencies in Miami-Dade County Creates Regulatory Concern*, draft dated July 24, 2007.

[18] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.

time for specified geographical areas. As the chart below reflects, Miami-Dade and Broward counties comprise 19 percent of the state's population of persons over age 64, yet host 46 percent of the licensed home health agencies in the state.[19] Although home health services are not limited to persons over the age of 64, this population predominates the market.

County	2006 Estimated Population over age 64		Number of HHA Licensees as of August 23, 2007	
	#	%	#	%
Miami-Dade	328,998	11%	651	35%
Broward	255,962	8%	214	11%
Miami-Dade & Broward	584,960	19%	865	46%
All Other	2,571,091	81%	1000	54%
Total	3,156,051	100%	1865	100%

Imposing a moratorium on the issuance of new licenses would limit the number of new home health agencies in the future, but it would not address the number of already licensed home health agencies. In addition, those home health agencies licensed prior to imposition of a moratorium would be able to address increased service demand without the benefits of a competitive environment that fosters cost containment and service excellence.

The Legislature could establish a cap on the number of new home health agency licenses issued by the AHCA, by the AHCA areas for a specified period of time (monthly or quarterly). The cap must not be arbitrary. Use of objective criteria, such as the ratio of licensed home health agencies within each of the AHCA areas to the population over age 64 may be one factor to use in setting the cap. For example, in Miami-Dade County, there is one licensed home health agency for every 505 residents over the age of 64; for Broward County, the ratio is one agency for every 1,196 residents over the age of 64. For all other counties, the average is one home health agency for every 2, 571 residents over 64.

The AHCA and the Associated Home Health Industries, Inc., (Association) have indicated that they are not aware of a current unmet need for home health services, generally. However, the AHCA has indicated that finding providers of home health services for medically complex children is difficult. Imposing a cap on the issuance of new licenses would still allow the entry of some new providers, while allowing the AHCA to concentrate resources on surveying existing home health agencies to help ensure that patients and clients are receiving quality services consistent with applicable standards and regulations.

Licensure Application Process & Inspections

Home health agencies typically apply for licensure by hiring consultants who prepare the applications and write the agencies' policies and procedures. In the South Florida region, particularly Miami-Dade County, the AHCA has seen an increasing number of initial and change-of-ownership applications for home health agencies that have very similar financial schedules. Although not identical, these financial schedules appear to be templates prepared by a few Certified Public Accountants for applicants to meet the initial minimum financial filing requirements and may not coincide with the home health agency's business plan and operations.

Effective October 1, 2006, with the passage of the Health Care Licensing Procedures Act,[20] a change in ownership (different legal entity or 45 percent of more of the ownership, voting shares, or controlling interest of a corporation not publicly traded on a recognized stock exchange is transferred or assigned) requires submission of an application for an initial license.[21] Prior to this change, the AHCA noted that the ownership changed frequently for home health agencies in South Florida without triggering submission of an initial application. Upon submission of an initial application, the AHCA has the opportunity to assess the ownership, management, and controlling interest of the new ownership and deny licensure to applicants that do not meet the statutory criteria to hold a home health agency license.

After the initial licensure survey, the AHCA conducts subsequent unannounced surveys. In the AHCA areas other than area 11, where Miami-Dade County is located, the first unannounced inspection generally occurs within the first 9-15 months and approximately every 36 months thereafter. Due to limited staffing and the number of licensure applications in area 11, the first unannounced inspection for home health agencies not applying for Medicaid or Medicare certification may not occur for 3 years. Surveys include on-site

[19] Source of population data: Office of Economic & Demographic Research website on 9/11/2007; Source of licensee data: AHCA Home Care Unit, Bureau of Health Facility Regulation, as of 8/23/2007.

[20] Ch. 2006-192, L.O.F.

[21] S. 408.807, F.S.

records review, staff interviews, and patient interviews. The AHCA currently has 267 staff statewide to conduct all initial and follow-up inspections of home health agencies and other facilities and services. In Miami-Dade County, there are 36 staff responsible for all initial and follow-up inspections. The staff in the Miami-Dade County area has responsibility for inspecting 3702 facilities, including other licensees such as hospitals, hospices, adult living facilities (ALF), and health care clinics.

The following chart depicts the number of initial applications received and the AHCA's efforts related to denial of non-compliant applications statewide.

Year	# Applications Received	# Attempted Denials	# Actual Denials *	# Applications Received Area 11
	Statewide			Dade & Monroe
2004	260	75	27	105
2005	281	86	39	129
2006	402	49	24	225

* The difference between attempted denials and actual denials can be attributed to correction of the ground(s) for denial, withdrawal of the application, or the facility closing after the notice of intent to deny was sent.

Medicare/Medicaid Certification

As of August 23, 2007, 907 (49 percent) home health agencies were not certified for Medicare or Medicaid. The following chart displays the number of licensed home health agencies that are also certified by Medicaid only, Medicare only, or both.

	# HHA Licensed	# Only Medicaid Certified	# Only Medicare Certified	# Medicaid & Medicare Certified	Neither Medicaid or Medicare
Miami-Dade	651	18 3%	39 6%	240 37%	354 54%
Broward	214	14 7%	44 21%	38 18%	118 55%
Statewide w/o Miami-Dade	1214	67 6%	395 33%	199 16%	553 46%
Total Statewide	1865	85 5%	434 23%	439 23%	907 49%

A significantly higher proportion of home health agencies in Miami-Dade County are certified for both Medicaid and Medicare. Furthermore, in Miami-Dade County: 40 percent of home health agencies are Medicaid certified compared with 22 percent in the other counties in the state,[22] while Miami-Dade County only accounts for 21 percent of the state's Medicaid population;[23] and in 2005 and 2006, 69 and 92 home health agencies became certified or had applications pending to be Medicaid and Medicare providers.

As of August 23, 2007, there were 224 pending Medicare/Medicaid applications. Of that number, 159 were from Miami-Dade County, 21 from Broward County, and 44 from the rest of the state. The following chart depicts activity for Medicare and Medicaid initial certification applications from 2003-2006.

Year	# Applications Received	# Failed inspection (denied)	# Resurveyed after Denial	# Applications Received	# Denied
	Medicare			Medicaid	
2003	79	2	0	42	1
2004	151	10	3	85	12
2005	204	18	4	94	13
2006	145	14	8	206	14

On October 23, 2007, the AHCA notified home health agencies seeking Medicare and Medicaid certification that, due to federal budget reductions, the CMS has assigned surveys for new home health agency certifications to a lower priority, requiring the AHCA to complete recertification surveys of existing home health agencies and complaint investigations first. Accordingly, Florida will not have federal funds available for initial certification surveys once all of the higher priority surveys are completed. The AHCA further notified home health agencies of an alternate option for a national accrediting organization to conduct the initial Medicare or Medicaid survey.

Quality of Care Concerns

Director of Nursing

A home health agency providing skilled services is required to employ a director of nursing who is a Florida licensed registered nurse with at least 1 year of supervisory experience as a registered nurse.[24] The director of nursing is responsible for overseeing the delivery of professional nursing and home health aide services and must be readily available at the home health agency or by phone for any 8 consecutive hours

[22] Only Medicaid Certified + Medicaid and Medicare Certified / # HHA Licensed.

[23] Source: AHCA Medicaid Program Analysis – Number of Medicaid Eligibles by Program-Group by County as of 9/31/2007.

[24] S. 400.462(10), F.S.

between 7 a.m. to 6 p.m. The director of nursing is also responsible for establishing and conducting an ongoing quality assurance program for services provided by the home health agency.[25] A home health agency that offers only home health aide and homemaker/companion services does not require a director of nursing.[26]

Changes in the administrator and alternate administrator require notification to the AHCA prior to or on the date of change and submission of documentation evidencing the statutory qualifications as well as background screening clearance documentation of the replacement.[27] No notification is required for changes in the director of nursing in between renewals of the home health agency's license.[28] The AHCA licensure staff has had conversations with nurses who resigned shortly after the home health agency license was issued. Home health agencies may operate for months, perhaps until license renewal, without a qualified director of nursing.[29]

A Director of Nursing may be a director of a maximum of five licensed home health agencies operated by a related business entity and located within one agency service district or within an immediately contiguous county. The increasing number, type, and severity of complaints and administrative action as discussed more fully below are indicative of inadequate management and oversight on the part of home health agencies of their licensed activities. The current limitation does not take into account the number of clients for which the director of nursing may have ultimate responsibility at any given point in time.

Complaints and Fines Assessed

Representatives from the AHCA and the Association have expressed concern that while the current number of complaints and cited deficiencies may not be alarming, the rapidly growing number of licensed home health agencies in one geographic area of the state will lead to a degradation in services. This is predicated on the increasing trend in cited deficiencies and the fact that the staffing level responsible for regulatory oversight has not been able to keep pace with the increase in licensed home health agencies. The AHCA received 663 complaints related to various allegations of home health care agencies during the 2-year period 2001-2002. During the 2-year period 2005-2006, the AHCA received 897 complaints, a 36-percent increase. This is less than the increase in the number of licensed home health agencies.[30] Not all of these complaints were confirmed after investigation by the AHCA. The number of home health agencies fined by the AHCA for serious and uncorrected violations of state laws and rules has increased over the past 5 years as follows: 14 in 2001; 25 in 2002; 43 in 2003; 35 in 2004, 43 in 2005; and 50 in 2006.

The AHCA may impose administrative fines for various classes of deficiencies ranging from $200 to $5,000 for each occurrence and each day that the deficiency exists.[31] Before a fine for a class III (act, omission, or practice that has an indirect, adverse effect on the health, safety, or security of a patient) or class IV (act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients) deficiency may be imposed, there must be a finding that the deficiency was uncorrected or repeated. The fining structure may not be adequate to serve as an effective deterrent to encourage timely detection and correction of deficiencies.

Violations of Federal Regulations

The AHCA conducts surveys of Florida licensed home health agencies that are enrolled in Medicaid and Medicare for compliance with federal conditions of participation based on the federal set of survey standards. There has been an increasing number of federal conditions of participation not met yearly from 2001 to 2006. Annually the number of federal conditions of participation not met has been 7 in 2001; 31 in 2002; 40 in 2003; 63 in 2004; 68 in 2005; and 84 in 2006. The number of home health agencies in Florida that are enrolled in Medicare has increased from 349 in 2001 to 729 in 2006.

Medicare/Medicaid Fraud

The AHCA's Bureau of Medicaid Program Integrity (MPI) is responsible for preventing and detecting fraud and abuse and performing inspections and investigations related to the Florida Medicaid program.

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[25] Rule 59A-8.0095(2), F.A.C.
[26] Rule 59A-8.0095(5), F.A.C.
[27] Rule 59A-8.0095(1)(b), F.S.
[28] Source: AHCA Most Frequently Asked Questions Home Health Agencies Question 28c., found at <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/definitions.shtml#a> (Last visited on September 24, 2007).
[29] Source: AHCA Home Health Unit.
[30] Data available for comparison in growth from August 1999 to August 2007 reflects a 57 percent increase.
[31] S. 400.484(2), F.S.

If the MPI suspects fraud or another criminal violation of state law is involved, the case is referred to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU) for further investigation and prosecution, if appropriate. The following chart depicts the number of investigations relating to home health agencies opened by the MPI for the last 3 state fiscal years.

Medicaid Program Integrity Investigations

County	2004-2005	2005-2006	2006-2007
Miami-Dade	26	45	113
Broward	5	6	4
All other	16	21	27
Total	47	72	144

Nineteen home health agencies have been terminated from the Medicaid program in Miami-Dade County since July 1, 2004.[32]

Any Medicaid recipient requiring more than 60 visits in a lifetime must have the additional visits authorized through a precertification process.[33] The AHCA contracts with a private entity for these precertification determinations. Utilization reports prepared by the AHCA indicate that in Miami–Dade County for fiscal years 2005-06 and 2006-07, Medicaid paid for an average number of visits per recipient by home health aides without associated skilled nursing services of 278.1 and 297.7, respectively. Medicaid paid on average for 124 and 162.6 visits for the same services during the same periods for all other counties in the state.

Some Medicaid-related fraud and abuse observations by the AHCA that could translate into quality of care issues include:

- The same home health aide being employed by multiple home health agencies and cumulative billings for that aide exceed 24 hours per day;
- Home health aides providing services to two recipients at the same time in different locations;
- Billing for services not rendered; and
- No changes in the patient condition from one assessment / re-certification period to the next.

The AHCA referred 3 cases to the MFCU in 2004, 7 in 2005, and 13 in 2006 for suspected Medicaid fraud. The MFCU opened seven home health agency cases in 2004, 17 in 2005, and 17 in 2006. The MFCU reports that from 2005–2007, Miami-Dade County centered cases accounted for approximately 70 percent of the new MFCU home health agency cases opened.

The MFCU reports that the type of fraudulent activities and schemes seen in Florida related to both Medicaid and Medicare home health services include:[34]

- Kickbacks to physicians to sign plans of treatment;
- Recruiting recipients to fake or exaggerate symptoms to qualify for home health services;
- Paying recipients for participating in billing of unnecessary or non-rendered services; and
- Collaborative arrangements between Medicare and Medicaid certified home health agencies to pass off some services (primarily home health aide services) provided to dually eligible recipients to providers enrolled in Medicaid.

Most of the fraudulent activity noted by the AHCA and the MFCU are actions that are already subject to criminal or administrative sanctions. Early detection and enforcement actions against these fraudulent activities are critical.

RECOMMENDATIONS

The Legislature should:

Impose a time-limited cap on the number of new home health agency licenses issued; crafted in a manner that allows a limited number of new home health agencies to be approved periodically by geographic area to bring more parity in the number of home health agencies available to serve the population throughout the state.

Require both the home health agency and director of nursing to notify the AHCA of a change in the director of nursing prior to or on the date of change.

Require the Department of Health and the AHCA to cooperatively develop a rule addressing standards of care related to responsibilities of a Director of Nursing for home health agencies. At a minimum, these standards should address oversight of skilled nursing services as well as personal care services provided by either employees or contracted staff, an ongoing quality assurance program related to those services, and maintenance of a monthly log of services performed by individual staff.

[32] Provided by AHCA's Medicaid Program Integrity Unit.
[33] *Florida Medicaid, Home Health Services Coverage and Limitations Handbook*, Agency for Health Care Administration, *supra:* note 10.

[34] MFCU's report to the Florida House of Representatives on October 2, 2007.

Limit the number of patients for which a director of nursing may be responsible.

Require the AHCA to conduct surveys of home health agencies more frequently, especially within the first 9-15 months of operation for all home health agencies throughout the state.

Enhance the administrative penalties that may be imposed for deficiencies to provide a meaningful and timely incentive for compliance.

Require the AHCA to review the precertification process for authorizing visits by home health agencies in excess of the 60 visits per lifetime cap, conduct an audit of the contract provider performing this function, and modify contractor performance expectations, if appropriate.

Require the AHCA to assure that the Medicaid payment system disallows payment for home health services ostensibly provided through the Medicare prospective payment system to a dually eligible recipient during the same 60-day episode.